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### St. Bartholomew's Hospital Journal,

JUNE, 1902.

*"Æquam memento rebus in arduis  
Servare mentem."—Horace, Book ii, Ode iii.*

### Some of the Results of Infantile Paralysis.

*A Clinical Lecture by Mr. BRUCE CLARKE.*

**C**ENTLEMEN,—I have chosen for my title to-day "Some of the Results of Infantile Paralysis," because the cases which may be arranged under this title form a well-marked group, and often lead to deformities for which instrumental as well as general surgical treatment is urgently demanded, and they form a large proportion of the cases that are met with in the Orthopaedic Department.

I do not propose to say much on the pathology of such cases, because I am dealing with the results of the disease and not with its earlier stages. But I may preface my remarks by reminding you that the disease in question usually occurs during childhood, though it is by no means absolutely confined to this period of life. As an Irishman would express it, there is such a disease as infantile paralysis of the adult.

The onset of such an attack is often overlooked both by patients and by those who attend to them. It comes on much in the same way as an ordinary cold, with some slight symptoms of malaise, and in all probability it is not until the child shows some disinclination or inability to move its legs that the true nature of the attack is discovered. It is usually the legs that suffer, though the attack may involve the arms and even some of the trunk muscles as well. It is rarely that the disease falls with equal severity upon all the parts affected. If such a patient is subjected to no treatment whatever a tendency to recovery begins usually a few days after the onset of the attack, but the recovery is rarely if ever a complete one. When it has reached a certain stage it comes to a standstill, and the child is commonly left with a more or less paralysed leg. The paralysis may be complete or confined to certain muscles or muscular groups. Leg paralyses more commonly persist than do those of the arm, but it is almost certain that some of the arm paralyses which one meets with and recognises for the first time at or about the age of puberty are in reality the sole remnant of an attack of infantile paralysis earlier in life, which has entirely passed out of recollection, and perhaps was never detected. The term anterior poliomyelitis points to the actual seat of the lesion which is associated with this disease, but it affords us no clue to its origin. It is commoner in summer than in winter, and is most probably dependent on some specific organism.

The *symptoms* of the disease when the paralysis is well established rarely offer much difficulty in diagnosis. The affected part (which I have already pointed out is usually

one of the legs) is smaller than its neighbour, livid, and subject to chilblains in winter. The skin is rough and harsh, and rarely hairy. It feels cold to the touch, and is usually shortened and deformed, with weak, loose joints that are quite insufficient to support the weight of the body. If the foot alone is paralysed it has probably assumed some position of talipes rendering walking difficult or impossible, and it is for this reason that the patient applies for treatment. A very brief examination of the foot and leg will probably show that the ankle and knee joints can be over-extended, and that their lateral ligaments are so weak that they can with difficulty be made to retain their natural shape and position. A loose condition of the ankle is more common than lateral movement at the knee. The side of the foot will probably be in the position of cavus, combined perhaps with that of equinus, equino-varus, or calcaneus. The extensor or flexor muscles, possibly both sets, are paralysed. And it may be as well to remark at this stage that *complete paralysis is generally far more easy to treat than partial, because there are no opposing groups of muscles to prevent the replacement of the limb in its natural position.*

There are but two conditions with which such cases are liable to be confounded, viz. infantile hemiplegia and hysteria. Of the causes of hemiplegia in early life we are entirely ignorant. It is usually assumed that they are dependent on some cerebral clot, due perhaps to the rupture of some vessel, perhaps in an attack of whooping-cough, and analogous to the subconjunctival haemorrhages which are familiar in the course of such attacks, but there is no absolute proof that this is the case. In such a condition the corresponding arm and leg are affected, though not always to the same extent, whilst in hysterical conditions the electrical reactions of the muscles in the affected limb show no deviation from the normal. At the present time I have under my care in Lucas Ward a woman who well illustrates these mistakes in diagnosis. She is just twenty, and with the exception of her paralysed leg enjoys the best of health, and bears all the marks of good health on her countenance. Some years back she was seized with an attack of unconsciousness, from which apparently she recovered in a few minutes, but her left arm and leg have been paralysed ever since. The arm has all but completely recovered its power, and can only be described as slightly weakened; but the leg is so flexed at the knee that it is practically useless, and she can only get about by means of crutches. There is also some loss of sensation in the leg. She was sent some time back to Dr. Lewis Jones as a case of hysteria for electrical treatment, but he soon appreciated the true state of the case, and handed her on to me to give her some apparatus which could enable her to walk. Her condition is both interesting and instructive from many points of view. The diagnosis was in the early stages attended with some

difficulty, and the resulting paralysis, as you will see if you look at the case, has fallen almost entirely upon the quadriceps extensor femoris group of muscles. The muscles below the knee are not strong, but the opposing groups are about equally powerful or equally lacking in power, whichever way you like to put it. In consequence of this condition the leg below the knee, though not strong, is quite movable and useful, but the limb as a whole is all but useless because the comparatively strong hamstrings are pulling the knee into a state of flexion, and there is no extensor group to counterbalance them. I am dwelling with considerable fulness on this, firstly, because you can look at it; and secondly, because though it is not a case of deformity resulting from infantile paralysis it will illustrate very vividly to you the problems which such a case presents, and what means must be taken to find an adequate solution for them.

At first I endeavoured to put the leg straight by dividing the hamstrings, and putting the leg upon a back splint. Some improvement took place, but was only of short duration; after a day or two it completely relapsed. I next attempted to make use of some of the hamstrings for the purpose of extensors, and made a long incision on either side of the thigh. I cut away the biceps and semitendinosus from their insertions, and attached them along with the sartorius and gracilis to the tendon of the rectus just above the patella. The operation left nothing to be desired, excepting only that it did not enable her to straighten her leg. The leg is straighter, but it is a long way off being a useful member. I have now advised her to consent to arthrodesis,—that is to say, to have her knee-joint fixed by removing the cartilage from the femur and tibia, so that a stiff joint may result. There is no other alternative but amputation, unless she is to go about on crutches all her life dragging a useless limb after her. You could not, I think, wish for a more complete picture of the damaging effect of paralysis, and much, if not all of it might have been prevented had an accurate diagnosis been made and suitable treatment applied in the earlier stages of the disease.

If suitable treatment is to be employed a knowledge of the means by which deformity is produced must be thoroughly understood. Up to some forty years ago the antagonistic theory of Delpech held its ground unchallenged. The facts which we have before us in this girl's knee may seem, at first sight, to prove the correctness of Delpech's views. The extensors of the thigh are paralysed, therefore it must be the antagonistic action of the hamstrings that has produced the deformity. *That they help to keep up the deformity may be readily conceded, but there is no evidence that in the first instance they produced it.* Such deformities are in reality brought about partly by the force of gravity, partly by pressure, and partly by the inability of the paralysed muscles to get the limb straight.

Added to this there is the well-known fact that muscles, ligaments, and indeed all the soft tissues readily undergo permanent weakening and shortening if their extremities are brought closer together for any considerable period. Perhaps the best instance of this law of growth is afforded by the results of, say, a fractured femur, in which three quarters of an inch of shortening has taken place. The muscles that surround the bone have accommodated themselves to the shortened bone long before the patient is able to walk.

The series of changes, then, by which this condition of permanent knee shortening was induced were as follows:

It was easy to bend the knee, whether the patient was sitting in a chair or lying in bed, but impossible to straighten it. The pressure of bedclothes and the force of gravity all helped in the same direction. There was no need for the posterior ligament of the knee-joint or the hamstring muscles to lengthen themselves out as they do under healthy conditions, and *after a while* they ceased to have the capacity for being straightened, and that is the condition in which we see our patient to-day. It is not the hamstrings that have produced the deformity, they have only accommodated themselves to circumstances, and had they been paralysed as well as the extensors the same deformity *might* have ensued. Mark, I use the word *might*, not *would*. The deformity would not have come about so easily, because nutritive shortening does not occur so readily in a paralysed as in a healthy muscle, and when the patient started to walk with crutches the force of gravity, unopposed by healthy hamstrings, would have helped to keep the leg straight.

If these facts had been correctly appreciated when the deformity first began to appear, the limb would have been kept straight by splints and daily movements, and the hamstrings and adjacent structures would have been prevented from undergoing nutritive shortening. Had this line of treatment been pursued, a couple of steel supports, one on each side of the affected leg, would be all that would be required,—at any rate the knee-joint would have been straight if it was not strong.

But let us turn our attention for one moment from a case of paralysis which affects the knee-joint to one that affects the muscles in the neighbourhood of the ankle, because the problem from an instrumental point of view is a far simpler one. If the muscles that pass over the front of the ankle-joint are paralysed, a tendency to toe-drop is almost certain to be present. The calf muscles have undergone nutritive shortening, and the patient becomes less and less able to walk with either comfort or safety, because every time the foot is moved forward the toe catches the ground, and is liable to trip him up. In other words, we have to do with a case of paralytic talipes equinus, in which the calf muscles have undergone shortening because the extensors are not strong enough to

put the flexors on the stretch, and the tendency of pressure and gravity combined has assisted in the same direction. If the calf muscles are cut so as to bring the foot up beyond a right angle, an instrument must be employed to keep it there, and for this purpose one of the best instruments is a boot with an outside iron to the calf, and with a toe-raising spring attached to it. It is perhaps hardly necessary to call attention to the fact that care must be taken to ensure that the spring is of suitable strength, neither too weak on the one hand nor too strong on the other.

But the effects of paralysis are often not confined to muscular paralysis alone; the bones and ligaments are usually greatly weakened, and the ankle is liable to move laterally. To obviate this condition it may be necessary to employ two irons, one on each side of the leg, and perhaps a varus and valgus T strap to steady the ankle. By the aid of these appliances it is often possible to make walking so easy that no deformity can be detected until attention is called to the surgical boot.

If the paralysis has affected the flexors of the calf instead of the extensor muscles, a toe-depressing spring must be substituted for the toe raiser.

If both sets of muscles are destroyed, no spring will probably be needed at all, as the tendency to deformity is far less even if the weakness is much greater.

Where the weakness is such that the leg, even when irons are employed, is useless for purposes of progression, and painful by reason of its bloodlessness and liability to chilblains, there is no alternative but amputation, but it is only as a last resource that this mode of treatment should be employed. When the leg is more extensively affected, and the muscles round the knee-joint are so far involved as to render it practically useless, the results of treatment are not so satisfactory as in the case of the ankle. Two irons are generally required, one on either side of the knee, and a draw-back knee-cap to keep the leg straight in extension. But the fact that the knee-joint must be flexed at least to a right angle, both in the kneeling and sitting posture, gives the flexors a chance of becoming permanently shortened, and with what disastrous results the case I have shown you gives ample proof.

If there is one thing which I hope I have made clear, it is that instrumental treatment must be begun early; in other words, that prevention is better and far easier than cure.

## Tubercular Meningitis.

*A Clinical Lecture delivered by Dr. GEE on June 13th, 1902.*

*(Reported by C. F. HADFIELD.)*

**G**N May 15th a boy was admitted to this Hospital with tubercular disease of the hip. On May 27th he developed tubercular meningitis, from which he died a few days later.

On May 30th a little girl entered the Hospital with headache and vomiting. On June 1st she died of tubercular meningitis.

On June 6th a young baby was admitted with the same disease, from which she died two days later.

Thus we see that within ten days there were no less than three deaths from tubercular meningitis—these in two wards only. Nor is such an occurrence at all unusual.

A disease which occurs with such frequency deserves your very close attention. Although so common it is in many cases quite impossible—I do not say difficult, but impossible—to diagnose in the early stages. Again, it is a disease which almost necessarily involves a fatal termination, and therefore mistakes in diagnosis and prognosis will be very liable seriously to injure your professional reputation.

I will distinguish between the primary and the secondary forms of the disease. When primary the patient has been quite well up to a certain date, after which he develops symptoms that can afterwards be definitely referred to tubercular meningitis.

When the disease is secondary it follows at the end of phthisis or other chronic tubercular disease. It is then very seldom diagnosed, seeing that it may only be the means of adding one or two fresh symptoms to a number of symptoms which already exist. Since, also, it only occurs in what I may call the closing scene, the diagnosis is seldom of any material importance.

Considering, then, the primary disease, I have set down five symptoms which mark the onset.

1. *Vomiting*.—This I regard as the most important symptom, as it is very seldom absent. It may be excessive; or, again, it may be slight and transient, and be put down to something indigestible which the child has eaten. Remember, then, that vomiting in a child may be the first symptom of tubercular meningitis.

2. *Headache*.—This may be absent or slight, but is sometimes very severe from the first. In babies I think that headache is sometimes the cause of constant screaming.

3. *Convulsions* are the first symptom in rare cases.

4. *Delirium*.—In the case I mentioned to you of the boy with hip disease delirium was the only symptom for two to three days, during which no diagnosis could be made. Delirium seldom occurs in young children, but only after the mental faculties are considerably developed.

5. *Fever* is nearly always present, and is sometimes the first sign.

These invasion symptoms are followed by a stage of disease marked by fever, headache, sometimes vomiting, sometimes delirium, constipation, and drowsiness. Sometimes the patient looks very ill, sometimes not. This indecisive stage of the disease, during which no certain diagnosis can be made, usually lasts for some time. The total duration of the disease is seldom more than twenty-four days, and it may be much shorter. Still I remember the case of a girl who was very ill for six weeks. She was seen by a number of medical men, but no certain diagnosis was made. This was largely owing—as it very frequently is in these cases—to the extreme restlessness and peevishness of the child, which made it impossible to use the ophthalmoscope or even to feel the pulse. To the experienced eye this restless state is often almost diagnostic. I have even given chloroform in order to examine the fundus of the eye, and have even then failed, owing to the rolling up of the eye under the upper lid. The case I speak of was the only child of a clergyman; she remained in this state for nearly six weeks. Many suggestions were made as to the cause of the condition, but it was only when the child became comatose, as they always do before the end, that I saw distinct choroidal tubercles with the ophthalmoscope. The existence of these showed that the child had only a day or two more to live, and she died forty hours after the onset of coma.

The fever is usually not high, and is seldom above  $102^{\circ}$ . It may be  $103^{\circ}$ , but is very rarely higher. Thus, to some extent, a high temperature militates against a diagnosis of tubercular meningitis. In some cases there is no fever at all, at least as often as the temperature is taken.

During this indecisive stage, whether it last two or three days or five or six weeks, the diagnosis is not certain. Then follows the final stage, when a diagnosis can be made. It may set in soon after the onset of the illness, or only two or three days before death. The diagnosis now depends on three classes of symptoms; (1) those referable to the brain, (2) those discovered by the ophthalmoscope, and (3) vital symptoms referable to the circulatory and respiratory systems.

(1) *Brain symptoms*.—Palsies are common. Sometimes the paralysis is local, and is seen most frequently in connection with the oculo-motor muscles, giving squints or dilated pupils. In other cases it is more general, and affects an arm or a leg. There may be hemiplegia. Aphasia,

which is a kind of paralysis, may be present, and is sometimes the first characteristic symptom of the disease. I remember a case showing it in an adult. (I may here say that I speak of adults as well as children. The disease is so little expected in adults that it is even more often overlooked than in children.) This case had convulsions with rigidity of the right arm and right side of the face, and a temperature of  $104^{\circ}$ . He became comatose, but after some hours the coma passed off, leaving him quite conscious but aphasic. The fundus was quite natural at this time, and there was no vomiting and no squint. Post mortem a focus of disease was found in the anterior part of the first temporal and inferior frontal convolutions on the left side, just where one would expect it to cause aphasia. I have known it to occur in children. Of other symptoms of this class, nystagmus, rigidity of the back, convulsions (especially at the end) and delirium (at any time) are all common. Coma is invariable at the end, but may come on earlier and pass off.

(2) *Ophthalmoscopic symptoms* are very important. The medical man who cannot use an ophthalmoscope cannot diagnose tubercular meningitis and many other diseases. Let me, therefore, urge you to make use of your opportunities here for learning the use of the instrument.

The two things to look for are optic neuritis and choroidal tubercles. I remember a case where there had been headache and fever at night for a fortnight. When I saw the patient the fever and cough might have been accounted for by typhoid, simple catarrh, whooping-cough, or acute tuberculosis affecting the whole body. The discovery of optic neuritis led me to diagnose the last with the utmost confidence. Ten days later there was slight paralysis of one side of the face, and the child died in a comatose condition. Post mortem tubercles were found in the meninges and most of the organs.

The optic neuritis may produce blindness. I once saw a poor Irish girl, the daughter of very ignorant parents, in whom loss of sight was the first symptom of illness. In better circumstances, and with less ignorant friends, no doubt other and earlier signs would have been noticed. She had "choked disc" in each eye, and soon died of tubercular meningitis.

If you see tubercles on the choroid, and there are any symptoms referable to the brain, the condition is quite diagnostic. Unfortunately this fact is of little use as the tubercles seldom appear more than two to three days before death, when the diagnosis has usually been already made.

(3) *The symptoms connected with the circulation and respiration* often combine, especially in the last stage, to give a flushed and heavy appearance of the face which one becomes able to appreciate. In both pulse and respirations the irregularity is the most frequent feature.

There is an almost infinite variety in the manner in

which these various symptoms are associated, and after much experience I find that no two cases are quite alike. Putting aside the choroidal tubercles, no one symptom or group of symptoms is pathognomonic. The more symptoms there are that point to the brain, the greater the probability that the brain is diseased. You are sent for to see a child with symptoms of acute brain disease. Tubercular meningitis is so far the commonest of all such diseases that it often comes to be a matter of probabilities.

As evidence of the difficulty of the diagnosis I will refer to a little child, only three months old, admitted on June 6th with a history of convulsions and great retraction of the head. After hearing the note read, and without very careful personal examination, I fear I rather jumped to the conclusion that she was suffering from *cervical opisthotonus*, a disease I was the first to describe many years ago. However, I was wrong, for the child died, and was found to have tubercular meningitis. The fact is that acute brain diseases are sometimes quite indistinguishable in children, especially in very young children in which the mental faculties have not developed.

In tubercular meningitis, then, a diagnosis of the primary form may be impossible until the patient is dying, and in the secondary form it is often not made at all.

The disease may be easily mistaken for a slight affection of the stomach. The child may be brought for vomiting and stomach disorder, and only some days later the medical man begins to suspect something far more serious. When obstinate constipation accompanies the vomiting, the condition simulates that of intestinal obstruction.

A child, two years old, suffering from these symptoms, was thought to require abdominal section. Examining the abdomen alone the surgeon could not feel satisfied that there was mechanical obstruction, and especially could find no evidence of intussusception. He therefore asked me to see the child. I thought it might be tubercular meningitis, but on examining the fundus I found no optic neuritis. Two days later, when I saw the child again, the bowels had acted well, and a highly marked optic neuritis had set in. Death resulted a week later. Such a case is not common, but it is easy to see how it may arise.

The disease at the outset may simulate typhoid. Again, it is not uncommon for a child to become weak and febrile for some time for no very apparent cause,—febricula. Early cases of meningitis may easily be mistaken for them. The presence of convulsions is of little use, as they may be connected with disease of the brain or be quite independent of it. The only course is to watch the further development of the case.

Lastly, it is important to remember that, especially in young women, tubercular meningitis may simulate hysteria.

## On Ophthalmic Treatment and Therapeutics.

*An Introductory Lecture by WALTER H. JESSOP.*

(Concluded from p. 120.)

**EAVING** the more general treatment, I would ask you to consider the treatment and remedies used in inflammations and conditions of the conjunctiva and the cornea. I associate these two structures as they are continuous with one another, and form the protective parts of the anterior or more superficial parts of the eyeball.

Starting first with the conjunctiva, it must be borne in mind that it forms a mucous membrane covered by delicate epithelium, and lines the inner aspect of the upper and lower lids (palpebral portion). It extends above and below to the fornix, and is then directed over the eyeball (ocular portion) as far as the limbus. At the limbus the conjunctiva is continuous with the cornea, forming the anterior portion of the epithelial lining of that protective coat.

I would especially warn you that when the lids are in contact the conjunctival sac becomes a closed cavity, except for the small openings of the puncta leading by the canaliculi to the nasal duct. These puncta, from the approximation of the lids, tend practically to be closed, especially when any discharge glues the lids together. It is therefore one of the most important points to be observed in treatment of conjunctivitis that the eyes should never be bandaged, but that free relief should be afforded to any discharge. One way to obtain this is to apply some simple ointment along the edges of the lids, especially before the patient goes to sleep. Such ointments may be boracic, vaseline, lanolin, cold cream, etc. The best and simplest way to apply them is to take a piece about the size of a hemp-seed on the clean finger, and to smear it on the inside edge of the lower lid, which is depressed for the purpose by a finger.

On dressing cases after operation I always apply some freshly made and aseptic boracic acid ointment on a piece of sterilised linen or lint next the eye in order to prevent the lids sticking together, and thus to allow free vent to the tears or any discharge from the eyes.

The conjunctival sac, lined by delicate epithelium and having glands secreting a lubricant for the cornea, is, in the healthy state, to all intents and purposes an aseptic cavity, the secretions apparently possessing an antiseptic property. Even in disease, except when the form is very severe, as in gonorrhœal conjunctivitis, a pathogenic microbe has slight chance of growth.

For this reason there is little use in employing antiseptics of any potency in the treatment of slight conjunctival affections. In such inflammations strong antiseptics act, as a rule, by destruction of the epithelium or irritation. I know no mucous membrane in the body that more resents the use of antiseptics. For operations on the eye as cataract I have

for a long time given up the use of anything stronger than distilled and sterilised water, and even think in most cases this might with advantage be dispensed with. For slight cases of conjunctival inflammation a solution of boracic acid (gr. 5-10 to the ounce) may be employed. Feeble as its antiseptic properties are, it seems to suit best the conjunctiva.

Lotions are easily applied by means of an eye-cup, which should be filled with the lotion and applied quite close to the eye. The eyelids are then opened under the fluid, which thus washes the conjunctival sac and surface of the cornea.

Another way is by a small ball syringe; the head should be thrown back, and the lotion should be allowed to flow from the inner canthus outwards, the lids being opened.

Failing these, a small sponge or pedgelet of absorbent cotton wool soaked in the lotion can be used in the same way as the syringe.

If a very efficient antiseptic lotion is needed, as in gonorrhœal conjunctivitis, the best is nitrate of silver (2 per cent.), but even in this strength it must not be used too much, as it may produce great irritation and even destruction of the conjunctival epithelium.

Perchloride of mercury solution (1 in 5000) is a good antiseptic, but not equal to the former.

As an astringent nothing is better than hazeline, about one drachm to the eight ounces.

A lotion I would recommend in the common though very intractable irritable eye associated with a gouty disposition, well called "hot-eye," is a mixture of salicylates (salicylate of soda 40 grs., salicylate of cocaine 3 grs., salicylic acid 1 gr., distilled water 8 oz.).

Drops for the eye are made as watery solutions, and generally are of the strength of one to two grains to the ounce.

In some cases it is advisable to use an oily menstruum, as castor or olive oil. This is especially the case when the full action of a drug, as atropine or eserine, is required. The objection to the oily mixtures is the smarting pain produced, but this is counterbalanced by the longer and stronger action, owing to the tears not being able to wash away the application.

Drops are generally applied to the conjunctiva by a small drop-tube with a piece of india-rubber at one end, by a glass rod, or by a camel's-hair brush. As an astringent for the mucous membrane, sulphate or salicylate of zinc (from one to two grains to the ounce) is the best, though alum or sulphate of copper may be used.

Quinine drops, 2 grs. to the ounce, are indicated in membranous conjunctivitis.

The conjunctiva, as the cornea, is easily rendered anaesthetic by cocaine, except when it is much inflamed. Solutions of cocaine used as drops are very beneficial in allaying irritation of the conjunctiva, and may be used up to 4 per cent. It is very important to remember that the patient should be warned not to expose the eye to dust or

foreign bodies for an hour after cocaine has been employed, as the liability to such an occurrence is increased owing to the enlargement of the palpebral fissure, the diminution in frequency of the lid wink, and anaesthesia.

*Lamelle* or *disks* made with gelatine and a little glycerine are a very convenient method of application to the conjunctiva as they are not so readily diffusible as drops. They can be very readily placed on the conjunctival surface of the lower lid by a small camel's-hair brush, and the exact amount of the drug can be better calculated than with drops. For cocaine they are employed as  $\frac{1}{200}$  grain or  $\frac{1}{30}$  grain.

The *ointments* used are generally made up with vaseline (soft paraffin), but sometimes conjunctivæ, as skins, will not tolerate vaseline; in such cases the basis may be cold cream, lanolin, etc. Boracic acid ointment is a very useful one for inflamed conjunctival edges of the lids; zinc ointment (30 grains of oxide of zinc to the ounce) acts also as a slight astringent.

The ointment for conjunctival troubles, as phlyctœnæ, and certainly the most generally used eye ointment, is compounded of yellow oxide of mercury and vaseline, and is known as *unguentum flavum*. Some years ago Mr. Jonathan Hutchinson said he should like to take a whole sheet of a daily paper for days, and simply print on it *unguentum flavum* for the eyes. It certainly acts in many cases almost like magic, especially when combined with massage of the eye. It is used of various strengths from one to ten or fifteen grains to the ounce.

Painting the lids, especially the conjunctival surface of the upper lid, in granular or purulent conjunctivitis is often necessary. This is done with a camel's-hair brush or, better, a probe covered with absorbent cotton wool. Solutions of nitrate of silver are generally used, from 4 to 20 grs. to the ounce, and after the application the conjunctival surfaces should be bathed with water containing a little chloride of sodium, in order to form the chloride of silver and stay the caustic action. Such applications should be used with care, as I have seen, from the too free use of nitrate of silver in ophthalmia neonatorum, the lids deformed afterwards from the resulting cicatrices, and entropion or ectropion produced. Another trouble is that nitrate of silver, if used too long, produces a yellowish-brown or slate-coloured staining of the conjunctiva. This is due to the staining of the elastic fibres of the sub-epithelial layers.

Other methods of treating inflammation of the conjunctiva, especially the follicular or granular variety, are by touching the surface lightly with a crystal of sulphate of copper, or by a stick called *lapis divinus*, composed of sulphate of copper, nitrate of potash, and alum. After these applications the conjunctival surface should be washed with water to prevent damaging the cornea by the escharotic.

The cornea has certain points in its anatomical and physiological nature that should especially be remembered in treatment. It is coated over with a soapy film from the conjunctival secretory glands, which keeps it transparent and polished, and thus prevents dust, etc., irritating it. If cocaine is much used the surface of the cornea tends to become dry, and foreign bodies much more easily lodge on it, and may produce ulceration from corneal abrasion. Hence the great care that must be taken in protecting the cornea by closing the lids after cocaine has been used. Any abrasion of the cornea and loss of the protective epithelium may be followed by serious ulceration, and hence escharotics, as strong nitrate of silver, must be applied with care.

When the corneal epithelium is abraded or ulcerated the chief symptoms are great pain and neuralgia—owing to the exposure of the nerves,—photophobia, and lachrymation.

The pain may be, as a rule, relieved by keeping the eye bandaged in order to prevent the lids rubbing over the abraded surface, and also to procure rest for the eye. In some cases cocaine drops or lotion relieve it, and atropine drops (two to four grains to the ounce) act also as a sedative.

The pain, if acute, may be much lessened by fomentations of belladonna and poppy heads.

For corneal ulceration when not acute, and nebulae left after keratitis, the best treatment is by the yellow oxide of mercury ointment (two to twenty grains to the ounce). For nebulae it should be placed on the inside surface of the lower lid, and the lids rubbed over the eye so as to produce massage of the cornea.

In conclusion I wish to impress on you the importance of properly applying heat to the eyeball in ocular diseases. There are two methods, by moist and by dry heat. The latter is best carried out by taking some absorbent cotton wool and heating it before a source of heat, or in a hot chamber, placing the wool as a pad over the shut lids, then covering it with some gutta-percha tissue or protective, and bandaging the eye; the pads should be frequently changed.

Another way is by a muff warmer.

Warm or hot moist applications are made by wringing out some absorbent cotton wool or lint in nearly boiling water, and placing it over the closed lids (care being taken that the cornea is not exposed) as hot as the patient can stand. A piece of gutta-percha tissue or protective is placed over the pad as before, and by this means the heat is kept up. Fomentations ought to be employed as hot as can be borne, and are used by soaking absorbent cotton-wool pledges or sponges in the nearly boiling mixture, and applying them to the lids.

After doing this for five or ten minutes, the eye should be bandaged up as directed above for moist heat application.

The fomentations most commonly used are boroglyceride, boracic acid, poppy heads, or belladonna,

### A Case of Placenta Prævia.

By G. F. HOLT, M.R.C.S., L.R.C.P.



**N**ON May 28th last I was called to see Mrs. S—, æt. 43, the mother of thirteen children, who was expecting to be confined in July. For the last two days she had been losing freely.

On examination the placenta could be felt lying nearly centrally over the os. My partner, Mr. Shelley, who arrived shortly, gave chloroform. I then turned by the combined method; after a slight delay the membranes were ruptured, and a leg together with a small piece of placenta brought down. The bleeding, which up to now had been considerable, ceased, and within an hour the uterus was emptied. The peculiarity (to us) in this case was the toughness of the membranes (which had to be scratched through with the nail), and the excessive quantity of liquor amnii. The patient, although still very anaemic, is making a good recovery.

### Impressions of Surgical Teaching and Technique in the United States of America.

By F. K. WESSELS, M.R.C.S., L.R.C.P.



SHALL only relate my experiences at the Johns Hopkins Hospital in Baltimore, the surgical routine of which is perhaps the most perfect of its kind in America.

The surgical work done at the hospital is divided into two distinct departments, viz. (1) general surgery; (2) gynaecology.

General surgery is under the direction of Professor Halstead, who is assisted in his work by two associate professors, several assistants, a house surgeon, two assistant house surgeons, and several interns. There are also surgeons in charge of the out-patient departments, and clinical assistants helping them. The professor of surgery is also chief of the clinic, and does the following teaching:—

1. A clinical lecture is delivered once a week to the junior, senior, and post-graduate students. The German plan is followed; several students are asked to examine a case brought into the clinic, and "quizzed" by the professor. The professor then gives a short account of the disease, or presents other similar cases, and delivers a course of lectures, the result of a more or less elaborate research.

2. Almost every morning the professor operates; and sometimes a short description of the operation or the tissues removed is given. The associate professor also conducts a "clinic" once a week, and operates several times a week.

One assistant has charge of the clinical laboratories, and gives several courses a year in surgical pathology. This course is an excellent one. The class is taken over all the tissues removed in the operating room, and the men are taught to prepare them for microscopical examination. A very valuable demonstration is given each week by Dr. MacCallum, the resident pathologist, on all the morbid materials collected in the course of the week from the post-mortem room. Those who cannot attend the post-mortems because of conflicting duties thus have an opportunity to study the tissues carefully under the guidance of the resident pathologist.

Each assistant and associate in surgery makes a speciality of some branch of surgery. Dr. Cushing gives a neurological clinic once a week, and also a course in operative surgery and surgical anatomy, particularly of the nervous system.

The house surgeon's office is a permanent one, and he presides over all the wards, and assists the professor in the operations. This position is a very enviable one, and is very much sought after; for not only can the graduate gain in a few years a large surgical experience, but the house surgeon at Johns Hopkins Hospital is consulted by practitioners in several of the central, eastern, and southern states. The office is usually held for several years, and so the "Chief" and his house surgeon become thoroughly accustomed to each other, and operations are performed with a dash and swing which is most fascinating.

The assistant house surgeons aid the house surgeon in his duties, and they in turn are assisted by "interns," whose term of office lasts for one year. They do the routine work, have charge of one or two wards each, and direct the students in their care of the cases.

This is in brief the compact machine which governs the fourscore or more surgical cases in the hospital.

The gynaecological surgery forms a very important branch in the Johns Hopkins Hospital, under the direction of Professor Kelly. This department is conducted almost exactly like that of general surgery, but gynaecological surgery seems to embrace almost all abdominal operations in women, and so the departments overlap more or less.

The students at the Johns Hopkins Hospital are considered the ablest group of medical undergraduates in the United States; only about fifty are allowed to enter every year, and the course extends over four years of nine months each.

Before entering the candidates must have graduated from a recognised college, and have a thorough knowledge of physics, chemistry, and biology in general, and must be able to read the German and French medical journals fluently. In this way a "freshman" is prepared to begin anatomy, physiology, and bacteriology immediately after entering the school. Pathology (including surgical patho-

Reproduced from the Memorial Tablet in the Church of St. Bartholomew the Less.



logy), pharmacology, anatomy, and medical jurisprudence are taken up during the second year.

The student devotes his last two years almost entirely to clinical work in the out-patient departments, wards, and clinical laboratories.

It might be interesting to some to give one's impressions as to the excellence of the education a graduate from Johns Hopkins receives as compared with that of a graduate from one of the English or Scottish universities.

1. The Johns Hopkins men receive a far more thorough training in the purely scientific side of medicine. Under the inspiring teaching of Professors Welch, Mall, Abel, Howell, and others, each presiding over a laboratory with unexcelled equipment, and each a leader in his own department, the students gain not perhaps as thorough a knowledge of the main points from the examination point of view, but an investigative knowledge of the medical sciences.

Several very valuable researches, both scientific and clinical, are completed every year by students before their graduation. For this reason also a very large proportion of students spend one or more years after graduation in research both in Germany and in local laboratories.

Recently large sums of money have been set aside by Messrs. Rockefeller and Carnegie for the encouragement of research in all scientific branches of learning. Medical graduates in America, therefore, who have a moderate amount of ability and a sufficiently thorough training are given an opportunity to spend some time in working out problems yet unsolved free of all expense.

This zeal for scientific research reacts very disadvantageously on the practical side of the medical education.

The bedside teaching in the surgical wards is almost exclusively done by the assistants and house surgeons, and thus the student does not find his clinical training so interesting.

The teaching in the out-patient department is not so systematically done, and the student does not receive very much personal instruction.

Large "clinics," such as those conducted in Germany and the United States, are very excellent, but cannot compare with the "grouping" of students which is resorted to in the London hospitals. The ambitious student perhaps accomplishes as much in his work as is done here, but the average men cannot possibly gain as much experience in clinical diagnosis of surgical diseases.

The surgical routine at Johns Hopkins differs in only a few points from that in vogue in England.

General anaesthesia is employed as seldom as possible. If given, ether is preferred, and is administered usually by means of a sponge inserted into a cone made of an ordinary towel stiffened with paper.

2. Schleich's method of administering cocaine in normal salt solution, 1 in 3000, is very much employed, and, unless a patient is very neurotic, he is advised to choose this method of cocaineisation for the less severe operative procedures. Thyroidectomies, amputations, appendicectomies, gastrostomies, operations for radical cure of hernia, cholecystotomies, and other major operations are regularly performed by this method with most excellent results.

Spinal cocaineisation is not much practised.

The "Kay-Schurer system" of sterilisation of dressings and water is employed, which has been or is being introduced in several London hospitals.

Catgut prepared by the "Camal method" is used by Dr. Kelly for all ordinary ligatures of small vessels and buried sutures, and for closing the abdomen. Dr. Halstead uses fine black Chinese twist silk for ligaturing small vessels and

bringing together the cut edges of fascial planes and peritoneum, but employs mattress silver wire sutures for apposing the muscular planes. Continuous silver wire sutures are also employed for the skin, but are inserted subcutaneously as buried skin sutures.

Sterilised silver foil is placed directly over the wounds when they are intended to heal by first intention, dry aseptic gauze heaped over this, and a stiffened outer bandage usually placed over the ordinary gauze bandages.

A great deal of attention is paid to the insertion of gauze drains in septic abdominal cases. Each gauze drain is surrounded by an envelope of protective, the object being as much as possible to prevent irritation of the wound edges and intestines, which is so troublesome if naked iodoform gauze is used. The drains are very carefully inserted, and none are allowed to come between the coils of intestines, the abscess cavity being thus surrounded by a "gauze drain wall."

In renal surgery, especially in the gynaecological wards, cystoscopy and ureteral catheterisation is a regular proceeding. The wax-tipped ureteral catheter and the flushing catheter for washing out the pelvis of the kidney are apparatuses which impress the visitor very much. The

work of the gynaecological side is considered more interesting by post-graduates in general.

What impresses one much is the youth of the assistant surgeons and gynaecologists. Boyish-looking men are seen to wield the knife from morning to night with great composure and dexterity.

On the whole the students follow the German text-books, and are encouraged to read these in preference to the smaller English manuals; but the average student knows more about the original work done by the London surgeons than the most widely read London undergraduates. Students are given references in each clinic and lecture to the original works on the subject under consideration.

One feature of the life and routine of Johns Hopkins Hospital is the number of medical societies which hold frequent meetings.

Dr. Osler is the idol of the hospital, and interests himself in every movement among the students. He is regularly seen at the meetings referred to above, and directs a great deal of the work.

Students and members of the staff are given every opportunity to publish research done in the many journals conducted by the various heads of departments. The *Johns Hopkins Hospital Bulletin*, published monthly, is a very fine little journal, and contains much that is interesting and profitable. Most of the papers read at the society meetings are printed subsequently in this journal.

Americans are very proud of Johns Hopkins Hospital and its teaching, and some of their great men predict that Europeans will be compelled in the near future to cross to their great centres to learn and study scientific problems, because of the magnificent facilities now promised or to be inaugurated in the near future.

### The Seventh Decennial Dinner.

 THE Nineteenth Annual Dinner of the Seventh Decennial Contemporary Club took place on Wednesday, July 2nd, at the Trocadero Restaurant.

Mr. James Berry was in the Chair, and seventy members were present. The toasts of "the King" and "the Club" were proposed by the Chairman, whose own health was proposed by Dr. Rolleston.

In the course of his speech the Chairman quoted a short poem, which we reproduce in full.

### "THE LAST SURVIVOR."

(After Oliver Wendell Holmes.)

Yes, already vacant places are showing all too fast,  
And the thought comes strangely o'er me, who will live to  
be the last ?  
When the twentieth century's decades through half their  
course have run,  
With his ninety winters burdened, will he dine—a club of  
one ?

Will he be an ancient surgeon who will turn his feeble gaze  
To the long-forgotten methods of antiseptic days ?  
Or an erudite physician, burdened with useless lore,  
When all drugs are patent extracts and prescribing is no  
more ?

Will wealth have crowned his efforts, a popular G. P. ?  
Have patients rich and titled dropped guineas as his fee ?  
Or in a crowded suburb will our last survivor dwell,  
And listen to the ringing of a ceaseless surgery bell ?

And will his name have figured 'mid those who honours win,  
Attached to learned papers or a royal bulletin ?  
Or will he reach his evening with neither fame nor wealth,  
A mute, inglorious brother, who doeth good by stealth ?

Here's to our last survivor, whoever he may be,  
Pathologist, physician, anatomist, G. P. ;  
We'll pledge him at his banquet, where memories will play,  
And conjure up around him the comrades of to-day.

### Notes.

WE beg to congratulate Mr. Howard Marsh on his re-election to the council of the Royal College of Surgeons.

\* \* \*

DR. DRYSDALE has been appointed Medical Registrar to the Hospital.

\* \* \*

MR. WEST has been appointed Junior Demonstrator of Anatomy.

\* \* \*

IN our last number we recorded the appointment of Mr. Christopherson as a Surgeon to the Egyptian Army, and we take this opportunity of congratulating him on so excellent an appointment.

\* \* \*

THE Lawrence prize and gold medal have been awarded to R. C. Elmslie; the Matthews Duncan prize and gold medal have been awarded to A. R. Neligan.

\* \* \*

At the distribution of honours in connection with the Coronation, a K.C.B. was conferred on Sir William

Church, and we beg to offer him our warmest congratulations on behalf of every one who is connected with the Hospital. We feel that this honour is only a just recognition of Sir William's invaluable services not only to St. Bartholomew's, but also to the College of Physicians and to the various Commissions which of late have claimed so much of his attention ; and we look forward with the utmost reluctance and regret to the day—unfortunately not far distant—when Sir William Church will cease to be our Senior Physician.

\* \* \*

THE list of Coronation Honours also included the names of three other Bart.'s men. Sir Alfred Cooper, who is Consulting Surgeon to the West London Hospital, and Sir W. J. Collins, who is well known in connection with London University and the London County Council, received a knighthood ; and a C.B. was conferred upon Mr. Ronald Ross, who has done most valuable work on malaria.

\* \* \*

THE Burrows prize and the Skynner prize have been awarded to E. G. Pringle.

\* \* \*

THE Horton Smith prize for this year has been awarded to Dr. E. Laming-Evans for a thesis on "The Bactericidal Action of the Blood of Typhoid Convalescents." The prize is given annually for the best M.D. thesis for each year at Cambridge ; it was established in 1899, and has therefore been won only three times, and we are glad to say that on two occasions a Bart.'s man has been successful. We hope that our prospective M.D.'s will maintain this excellent precedent.

\* \* \*

PROBABLY many of our readers have had no opportunity of seeing the tablet in memory of Mr. Vernon which was placed in the church of St. Bartholomew the Less by Mr. Vernon's house surgeons.

An old Bart.'s man was good enough to present us with an admirable photograph of the tablet, and we have published a reproduction of the photograph in the hope that it will interest those who had the privilege of knowing Mr. Vernon.

\* \* \*

"THE old order changeth, giving place to new," and we are extremely sorry that Mr. Mundy and Mr. Douglas, who have resigned their appointments in the "rooms," will shortly be leaving the Hospital ; we believe, however, that they are now experts on all public health matters, and we wish them every success.

\* \* \*

THE Shuter Scholarship has been awarded to J. K. Willis, of Queens' College, Cambridge.

\* \* \*

THE Past and Present cricket and tennis matches took place on June 11th at Winchmore Hill. The afternoon

was sunny and pleasant, the band discoursed sweet music, the cricket and tennis were excellent, and Mr. and Mrs. Gibbs and their attendant satellites ministered to our bodily needs. But unfortunately very few people were there to enjoy these varied pleasures. Mr. Bowlby, Mr. Waring, and the Warden honoured us with their presence, and the nursing staff was fairly well represented ; but the student was conspicuous by his absence. For our own part we spent a most delightful afternoon, but we must confess to a feeling of regret that larger numbers were not present to share our enjoyment.

\* \* \*

IT is with deep regret that we have to record the death of Dr. C. H. Barnes, who had only recently left the Hospital and taken up private practice at Highgate. He was taken ill on May 26th with tonsillitis, which ultimately proved to be diphtheria. He was attended by his partner and by Dr. West, but died on June 10th after an illness of about a fortnight.

\* \* \*

FROM an athletic point of view the Hospital record for the past school year is not altogether so satisfactory as might be wished ; but two recent victories have done much to retrieve our position, and we heartily congratulate those who contributed to our success in the Inter-Hospital sports and the shooting. We had hoped for a victory in the sports, but probably no one anticipated that we would win so handsomely. Our tie with St. Thomas's for the Armitage Cup is equally gratifying both in that the result was obtained after a very uphill struggle, and also that for the first time in our history the shooting cup will help to adorn the Library. We hope soon to be able to add the water-polo championship to our list for this year.

\* \* \*

ON July 18th the distribution of prizes will take place in the Great Hall at 3 o'clock. Sir J. Dimsdale, Bart., M.P., will give away the prizes, and Sir Trevor Lawrence, Bart., will preside. There will be afternoon tea in the square subsequently.

This innovation is a very welcome one. Some years ago it was the custom to hold the prize distribution in the Great Hall, and we had the pleasure of hearing a most instructive address from Mr. Luther Holden on one of those occasions. But of late the prizes have been distributed in the comparative seclusion of the School Committee Room, no doubt on the ground that its atmosphere was most suitable to such an occasion. The School Committee Room, however, was hardly large enough, and we are very glad that a return has been made to the Great Hall. Moreover it is most appropriate that the head of the City should be present at the prize day of the only medical school in the City, especially as he is a Governor of the Hospital, and it is hoped that every one will be present to welcome the Lord Mayor.

By an error on our part the names of the winners of the Junior Scholarships were misplaced in the April number of this JOURNAL. The order should be (1) A. L. Giuseppi, (2) H. Quick.

### Amalgamated Clubs.

THE Hospital Annual Sports were held at Stamford Bridge on Tuesday, June 17th, in perfect weather. The band of the T Division, Metropolitan Police, were in attendance, and played selections during the afternoon to a fair number of spectators.

The entries for the races, we were glad to notice, were considerably larger than those of last year, notably those of the 120 yards handicap.

H. E. Graham and P. Gosse shared between them the honours of the afternoon; the latter especially ran in very good form, carrying off the first prize in the half-mile and the mile, the second in the two miles steeplechase (open to all hospitals), and third in the 120 yards handicap. The prize for the mile was presented by W. Bruce Clarke, Esq., F.R.C.S., and was an exceptionally pretty silver card-tray; while that for the half-mile was given by Messrs. Benetfink.

The freshers' race (220 yards)—always an event of interest—was easily won by W. B. Griffen, who also ran very well in the 120 yards and the quarter-mile; he ought to do very well next year. The Junior Staff race was won by Whitwell, who also carried off the first in the 120 yards hurdles.

W. H. Orton was in fine form, winning the 100 yards; he ran H. E. Graham very close for first place in the 440 yards, also carrying off second prize in the 120 yards handicap, being just beaten by L. Murphy, to whom he had to give eight yards.

In the high jump D. M. Stone from scratch jumped 5 feet 4½ inches, H. T. Wilson being second.

The two miles steeplechase (open to all the hospitals) is a new item in the Sports, and had it not been that our Sports were fixed too near those of some of the other hospitals we might have had a larger entry. Three outsiders entered for the race, but failed to turn up. The starters were J. G. Gibb, P. Gosse, and F. A. Izard. Gibb started off in his usual fine form, and soon took the lead, which he managed to maintain to the finish; his time was 11 min. 50½ sec. P. Gosse was second.

Our thanks are due to A. A. Bowlby, Esq., F.R.C.S., who very kindly consented to start the races; to the judges, Dr. Drysdale, H. J. Waring, Esq., F.R.C.S., P. Furnival, Esq., F.R.C.S. (of the London Hospital); and to W. D. Harmer, Esq., F.R.C.S., all of whom rendered us most valuable assistance.

Mr. Bruce Clarke, our President, very kindly consented to present the prizes in the place of Mrs. Bruce Clarke, who, we regret to say, was unable to be present owing to ill-health. We trust that on some future occasion she will honour us with her presence. After the distribution of the prizes a hearty vote of thanks was proposed to the President by the Secretary.

The programme was as follows:

I. 100 yards (level) Challenge Cup (presented by A. A. Bowlby, Esq.).		
1. W. H. Orton.		2. B. Hudson.
Time—11 sec.		
II. One Mile Handicap (1st prize presented by W. Bruce Clarke, Esq., F.R.C.S.).		
1. P. Gosse.		2. H. E. Graham.
Time—4 min. 37½ sec.		
III. Weight Handicap.		
1. H. E. Boyle, 37 ft. 10 in.		2. R. Douglas.
IV. 440 yards (level) Challenge Cup (presented by Mrs. Harrison Cripps).		
1. H. E. Graham.		2. W. H. Orton.
Time—55 sec.		
V. Long Jump (Handicap).		
1. J. R. Lloyd, 18 ft.		2. G. M. Levick.
VI. 120 yards Handicap.		
1. L. Murphy.		2. W. H. Orton.
3. P. Gosse.		
Time—12½ sec.		

VII. Freshers' Race (220 yards level) Challenge Cup (presented by W. S. A. Griffiths, Esq., M.D.).	1. W. B. Griffen.	Time—26½ sec.
VIII. 120 yards Hurdle Handicap.	1. H. Whitwell.	2. T. M. Body.
	Time—20½ sec.	
IX. Half-mile Handicap (1st prize presented by Messrs. Benetfink, Cheapside).	1. P. Gosse.	2. H. E. Graham.
	Time—2 min. 4½ sec.	
X. Throwing the Hammer.	1. H. E. Graham, 77 ft. 11 in.	2. T. M. Body, 67 ft. 1 in.
XI. Junior Staff.	1 (2nd prize). H. Whitwell.	Time—12½ sec.
XII. High Jump (Handicap).	1. D. M. Stone, 5 ft. 4½ in.	2. H. T. Wilson.
XIII. Two Miles Steeplechase (open to all hospitals).	1. J. G. Gibb.	2. P. Gosse.
	Time—11 min. 50½ sec.	

### CRICKET CLUB.

#### ST. BART.'S v. LONDON HOSPITAL.

Played at Chiswick Park, June 9th, 1902.

#### SCORES.

ST. BART.'S.	LONDON HOSPITAL.
C. F. Nicholas, b Roberts	2
C. M. H. Howell, b Roberts	2
W. S. Nealor, c Walters, b	
A. H. Jacob	3
L. V. Thurston, c Sparrow, b	0
W. Griffen, not out	24
C. A. Anderson, c Sparrow, b	0
G. G. Ellett, b A. H. Jacob	0
T. Eckstein, c Simpson, b	
A. H. Jacob	0
C. Elliott, b Roberts	1
G. F. Page, b Roberts	0
H. E. Stanger-Leathes, c	
Roberts, b Waldron	13
Extras	12
Total	57
	—
	151

#### ST. BART.'S v. HON. ARTILLERY CO.

Played at Finsbury, June 21st, 1902.

#### SCORES.

ST. BART.'S.	HON. ARTILLERY CO.
W. S. Nealor, not out	119
W. Griffen, c Waigh, b	
Chapman	16
C. A. Anderson, b Terry	33
C. M. H. Howell, c Adams, b	
Terry	61
L. V. Thurston	
C. F. Nicholas	
T. M. Body	did
H. E. Stanger-Leathes	not
C. Elliott	bat.
L. L. Phillips	
G. F. Page	
Extras	6
Total	235
	—
	12

## PAST v. PRESENT.

Played at Winchmore Hill on June 11th. The day was an ideal one for cricket, and a very fair number of spectators were present during the afternoon, among whom were Dr. Calvert, Mr. Bowby, Mr. Waring, and several of the sisters. Students, however, did not come in at all as many numbers as they might and should have done. It was a pity that the Present team was so weak—an operative surgery class keeping more than one away. The Past team was, however, a good one, and they won the match fairly easily for the first time since its institution. Scoones, Nimmo, Nunn, and Talbot all batted well, and the former declared with eight wickets down for 145. The Present had plenty of time to make the runs, but they all, with the single and marked exception of Anderson, failed; he hit freely and well for 60. Pank, for the Past, bowled in great form, taking 5 wickets for 18 runs—the last 4 in 4 balls. The Past, therefore, won by 2 wickets and 48 runs.

## SCORES.

## PAST.

H. J. Pickering, b Griffen	0
H. E. Scoones, b Elliott	24
F. H. Nimmo, run out	33
H. E. G. Boyle, b Griffen	8
C. G. Watson, b Griffen	2
J. W. Nunn, not out	20
E. Talbot, c sub, b Elliott	22
H. Whitwell, b Elliott	0
H. W. Pank, not out	12
T. M. Body	0
L. B. Rawling	0
Extras	24
Total	145

## PRESENT.

W. S. Nealor, b Pank	1
W. Griffen, c Nimmo, b Boyle	3
C. A. Anderson, b Nunn	60
C. Elliott, c and b Nimmo	13
G. H. Adam, c Nunn, b Nimmo	1
B. Hudson, not out	8
L. L. Phillips, c Boyle, b Nunn	2
C. O'Brien, b Pank	0
A. H. Hayes, b Pank	0
G. F. Page, l-b-w, b Pank	0
Extras	9
Total	97

## RIFLE CLUB.

The Inter-Hospital competition for the Armitage Cup took place this year on Wednesdays, May 28th, June 11th, and June 18th. On the first two shoots St. Thomas's Hospital was leading by thirty-nine points, but owing to the excellent shooting of Morris, Brown, and Read on June 18th we gained all the points we had fallen behind, and the competition resulted in a tie between St. Thomas's and St. Bartholomew's Hospitals.

It has therefore been decided that each hospital shall hold the Cup for six months, and our Library will, in consequence, contain yet another Cup from January to June next. This is the first year in which our Hospital has been successful in Inter-Hospital matches, and it is hoped that we shall continue to be so.

## SCORES.

## May 28th.

ST. BART.'S.	Pts.
1. A. C. Brown (capt.)	86
2. J. Morris	82
3. P. A. Dingle	75
4. E. A. Wright	74
5. T. W. Burne	42
6. N. Bennett Powell	60
Total	419

## June 11th.

ST. BART.'S.	Pts.
1. A. C. Brown (capt.)	86
2. J. Morris	89
3. P. A. Dingle	76
4. W. R. Read	77
5. W. W. Jeudwine	73
6. E. A. Wright	80
Total	481

St. Thomas's	450	St. Thomas's	489
Guy's	420	Guy's	448

## June 18th.

## ST. BART.'S.

1. A. C. Brown (capt.)	88
2. J. Morris	96
3. P. A. Dingle	83
4. W. R. Read	88
5. W. W. Jeudwine	83
6. S. H. Andrews	80
Total	518
St. Thomas's	479
Guy's	450

The following matches were arranged, with the result that six have been successfully contested and two lost:

SCORES.			
Opponents.	St. Bart.'s.	Result.	
Dulwich College	424	351	Lost.
St. Paul's School	331	351	Won.
Eastbourne College	255	306	Won.
Whitgift Grammar School	297	306	Won.
Lancing College	256	306	Won.
Cooper's Hill	330	270	Lost.
Rugby School	335	338	Won.
Highgate School	393	462	Won.

## THE PRIZE MEETING.

The Rifle Club Prize Meeting, held on Thursday, June 19th, was very successful, the entries for the various competitions exceeding those of previous years. The day was fine and bright, and the wind slight; it therefore did not interfere in any way with the shooting.

The following is the result of the competitions:

The Grand Aggregate Challenge Cup (presented by Mrs. Waring).

1. J. Morris. | 2. A. C. Brown.  
The Club Aggregate Challenge Cup (presented by Messrs. Benetfink and Co.).

1. R. Fuller. | 2. J. Morris.  
The Club Competition.

1. R. Fuller. | 2. J. Morris.  
Rapid Firing.

W. W. Jeudwine.

Junior Staff. J. C. Izard.

## LAWN TENNIS CLUB.

## INTER-HOSPITAL CUP TIES.

## 1ST ROUND.—ST. BART.'S v. GUY'S.

This match was played at Chiswick on Wednesday, July 2nd, and ended in a fairly easy victory for Guy's. Our prospects for the Cup were not very good, only two of last year's men, Hunt and Pope, being eligible.

## SCORES.—SINGLES.

E. H. Hunt beat F. Lucas, 6-4; 7-9, 6-3.
J. C. Slade lost to F. Palmer, 9-7; 1-6, 6-4.
A. Hamilton lost to E. Jupp, 3-6; 6-2, 6-2.
C. A. W. Pope lost to B. H. Wedd, 7-5; 2-6, 4-6.
P. Black lost to C. Winkworth, 8-6, 6-4.
P. W. Leathart lost to A. Zorab, 8-4, 9-7.
Score in favour of Guy's 5-1.

## DOUBLES.

Jupp and Zorab—
beat Leathart and Slade, 6-3, 6-4.
lost to Hunt and Pope, 4-6, 4-6.
Palmer and Lucas—
beat Hunt and Pope, 6-2, 6-4.
lost to Hamilton and Black, 1-6, 4-6.
Wedd and Winkworth—
lost to Hamilton and Black, 2-6, 3-6.
beat Slade and Leathart, 6-4; 2-6, 6-1.

## SCORE.

St. Bart.'s 3. | Guy's 3.  
Total in favour of Guy's 8-4.

## DRAW FOR THE CUP TIES.

## 1ST ROUND.—ST. BART.'S v. GUY'S.

London  
St. Thomas's } A bye.  
St. George's

## SWIMMING CLUB.

## FIRST CUP TIE.

## BART.'S v. GUY'S.

The first round of the Cup tie was played off at 3 p.m. on June 20th at Southwark Baths. Guy's won the toss and elected to defend the deep end first. On starting Stone was the first on the ball, and after a few passes he shot a goal for Bart.'s in the first half-minute. After this Guy's pressed, but were kept out, and by half-time Stone had succeeded in scoring twice more. It seemed as if we were going to have a walk over, but after changing ends Guy's were seen to more advantage, and Moon handed in a ball from just outside goal. The game after this was very even, and neither side scored again till nearly time, when Moon shot another goal for Guy's, thus leaving Bart.'s winners by three goals to two. For us Stone and McDonagh played a very good game, and Hanschell defended goal well. The next match for the Cup tie is Bart.'s v. Thomas's, the date of which is not yet decided.

Team.—H. M. Hanschell (goal); R. C. P. McDonagh and C. F. O. White (backs); J. G. Watkins (half-back); D. M. Stone, R. I. Douglas, and H. N. Wright (forwards).

## Correspondence.

*To the Editor of the St. Bartholomew's Hospital Journal.*

DEAR SIR,—I have just read with sorrowful interest the "In Memoriam" of A. N. Weir, which appeared in the April number of the Hospital JOURNAL, and which I have been anxiously waiting for since I read the brief notice of his untimely death in the January number.

Dear old "Ike" Weir was one of the very best of "Bart.'s" men; of his kind few are known in a lifetime.

I sincerely hope that something more than a brief "In Memoriam" in the JOURNAL will be done by his old Hospital to perpetuate his memory. I am sure every "Bart.'s" man who knew Weir as fellow-student, "H. S.," and Demonstrator will be only too pleased to contribute, as his means permit, something towards such an object, and I shall be honoured in adding my small share.

I am, yours very sincerely,  
W. B. MERCER.

*To the Editor of the St. Bartholomew's Hospital Journal.*

DEAR SIR,—Your reviewer seems to me to have been unduly and unnecessarily severe in his critique of Dr. Roberts's book on "Female Pathology."

Surely it is the duty of a reviewer to take a much more comprehensive view of a book than he seems to have done, and to base his judgment on main rather than side issues. As an instance, Dr. Roberts states that flexions and versions do not cause congestion of the uterus, but your reviewer takes him seriously to task for not "discussing in a scientific spirit" a variety of retroflexion which only occurs in 10 per cent. of all cases of that displacement. Again, if your reviewer had attended Dr. Champneys' lectures he would understand the reference to the size of the normal uterus—"it can be sent by post for a penny." Nothing, it seems to me, could bring home to the mind of an average student the size and weight of a normal uterus better than this. The illustration may be unscientific, but it is none the less striking.

The book contains much sound teaching, and, as Dr. Roberts states in his preface, is founded on the views of the late Dr. Matthews Duncan and his successors at the Hospital. Surely to most of us this is a sufficient guarantee of the soundness and truth of the views expressed, and of its utility as a book of both reference and instruction.

Yours, etc.,

J. A. WILLETT.

*To the Editor of the St. Bartholomew's Hospital Journal.*

DEAR SIR,—From the letter which you have forwarded to me, Mr. Willett has evidently misunderstood the spirit in which the review of Dr. Roberts's book was written. It was not my intention to deny for a moment that the work contained much sound teaching, and had a very real value of its own. If its many excellencies were touched upon too lightly it was from inadvertence and not from design.

I take it, however, that any criticisms of a just and reasonable nature will be welcomed by the author, and are of real value to him when he is called upon to prepare a second edition for the press. Bearing this in mind, I hold it is the duty of a reviewer to point out inaccuracies and defects.

If my words appear "unduly and unnecessarily severe," it can only be because I have expressed myself unfortunately and failed to convey my true meaning, and I am glad to have this opportunity of correcting an erroneous impression.

It was as a text-book of pathology that I criticised the work. A text-book of pathology for advanced medical students should be written in scientific terms, and colloquial expressions which are entirely appropriate and of the greatest value in a clinical lecture are out of place in a purely scientific treatise.

To write a book dealing with the pathology of the female pelvic organs, apart from clinical aspects, is a task of the very greatest difficulty; but as such the work was sent to me for review, and as such I criticised it.

If to any mind the idea has been conveyed that the work is not likely to prove of great value to students preparing for examinations in obstetrics I hasten to correct it; it is precisely to these, and particularly to such as are preparing for the higher examinations, that the work is likely to prove of real assistance. YOUR REVIEWER.

## Review.

A TEXT-BOOK OF PHYSICS; WITH SECTIONS ON THE APPLICATION OF PHYSICS TO PHYSIOLOGY AND MEDICINE. By R. A. LEHFELDT, M.A., D.Sc.

In this book the author has attempted, in an elementary work on physics, not only to present to the student or general reader the main principles of the subject, but also to give an account of recent advances and of applications which have lately been made to chemical and physiological questions. Moreover, in the treatment of this section of the subject, care has been taken to state clearly the results arrived at and their general bearing, rather than to describe

the methods, often very intricate and unconvincing except to the physicist and mathematician, by which these results were attained. Thus sections are found dealing with the modern developments of the subject of osmotic pressure and its relation to the lowering of freezing-point and the raising of boiling-point of solutions. A whole chapter is devoted to the explanation of chemical equilibrium and the law of mass action, and numerous examples of the application of the latter to chemical reactions and to the conditions of equilibrium in a chemical system are considered. Thus, as a deduction from the law of mass action and the ionic theory of salt solutions, there is every reason to believe that, when aqueous solutions of two neutral salts—for example, potassium chloride and sodium nitrate—are mixed, there are present in the solution in a state of equilibrium the four salts, potassium chloride, potassium nitrate, sodium chloride, and sodium nitrate. On altering the conditions, by evaporating the solution, etc., the least soluble salt of those possibly present crystallises out; in the case in question potassium nitrate first separates.

The "phase rule" is explained, and attention is drawn to the fact that in the aeration of the blood an instance is found of this important generalisation.

Another feature of the work is the description of new methods and forms of apparatus; the Töpler vacuum pump, Beckmann's apparatus for determining the boiling-point and freezing-point of solutions, and Sprengel's pyknometer for the determination of specific gravity are described. It is to be regretted that in all cases diagrams have not accompanied the description.

The book is free from misprints, although on p. 144, line 6, the word "solvent" should obviously be read for "dissolved substance."

Dr. Lehfeldt has maintained the reputation for lucid explanation gained by his previous writings.

### The Rahere Lodge, No. 2546.



THE Installation Meeting of the Rahere Lodge, No. 2546, was held in the Great Hall of St. Bartholomew's Hospital (kindly lent for the occasion by the Treasurer and Almoners) on Tuesday, June 10th. Messrs. John C. Baker, M.B., and Wilfrid H. W. Attlee, M.B., were initiated into Freemasonry, and Bros. Cross, Griffith, and Drysdale were elected members of the Standing Committee. W. Bro. Abraham, M.D., the outgoing W.M., installed his successor, Bro. George H. R. Holden, M.D., as W.M. for the ensuing year. Bro. Holden then invested the following as his officers:—W. Bro. Ernest Clarke, P.M., F.R.C.S.Eng., S.W.; W. Bro. J. H. Gilbertson, P.M., P.P.G.D.Herts, J.W.; W. Bro. The Rev. Sir Borradale Savory, Bart., P.G.C., Chaplain; W. Bro. Clement Godson, P.G.D., M.D., Treasurer; W. Bro. D'Arcy Power, P.G.D., F.R.C.S.Eng., Secretary; Bro. H. J. Waring, F.R.C.S.Eng., S.D.; W. Bro. Haig Brodie, P.M., P.P.G.D.Surrey, M.D., J.D.; W. Bro. F. Swinford Edwards, P.M., F.R.C.S.Eng., Dir. of Cerms.; Bro. J. H. Drysdale, M.D., Asst. D. of C.; Bro. G. H. Robinson, Mus. Bac., Organist; Bro. H. W. C. Austen, M.D., I.G.; Bro. M. J. Anderson, Steward; Bro. W. H. Cross, Steward; Bro. C. H. Cossens, Assistant Steward; Bro. M. L. Trechmann, F.R.C.S.Eng., Assistant Steward; Bro. S. R. Scott, M.B., Assistant Steward.

The Lodge adopted a resolution approving of the formation of a Royal Arch Chapter of the Hospital Lodges to be affiliated to the Rahere Lodge, and appointed W. Bros. Holden and D'Arcy Power to serve as representatives on a sub-committee to carry the proposal into effect.

A past master's jewel was unanimously awarded to W. Bro. Abraham for his services to the Lodge during his year of office, and presented by W. Bro. Holden. Bro. Abraham, in reply, expressed his sincere thanks.

The report of the Audit Committee was received and adopted. It showed that the finances of the Lodge were in a satisfactory condition, and that the sum of £60 18s. had been given in charity during the past year.

A grant of £5, as a first instalment, on behalf of a Brother in distress owing to ill-health, was voted unanimously.

The Brethren subsequently proceeded to Frascati's Restaurant, where the banquet was held. The attendance was a large one, and a very enjoyable evening was spent, an excellent entertainment being provided by Bros. Walter Churcher and Astley Weaver and others.

### Calendar.

July 15.—On duty. Sir Wm. Church and Mr. Langton.  
 " 18.—On duty. Dr. Gee and Mr. Marsh.  
 " 19.—S.B.H. Cricket Club v. Surbiton, at Surbiton.  
 " 22.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
 " 24.—Junior Scholarship Examination.  
 " 25.—On duty. Dr. Hensley and Mr. Walsham.  
 Summer Session ends.  
 " 29.—On duty. Sir Lauder Brunton and Mr. Cripps.

Aug. 1.—On duty. Sir Wm. Church and Mr. Langton.  
 " 5.—On duty. Dr. Gee and Mr. Marsh.  
 " 8.—On duty. Sir Dyce Duckworth and Mr. Butlin.  
 " 12.—On duty. Dr. Hensley and Mr. Walsham.  
 " 15.—On duty. Sir Lauder Brunton and Mr. Cripps.

### Examinations.

#### UNIVERSITY OF CAMBRIDGE.

*Surgery and Midwifery.*—H. W. Atkinson, E. A. A. Beck, H. N. Burroughes, J. F. H. Dalby, H. H. Dale, G. G. Ellett, H. N. Gould, B. Hudson, P. W. Leathart, H. D. Ledward, H. Statham, F. Whitaker.

*Medicine.*—J. F. Alexander, J. N. Benmore, F. R. Carroll, H. H. Clarke, R. L. V. Foster, W. W. Jeudwine, G. E. Loveday, J. McBryde, C. de C. Pellier, G. H. L. Whale, W. W. Wingate-Saul.

### Appointments.

ATKINSON, STANLEY B., appointed Senior House Physician at City of London Chest Hospital, Victoria Park.

\* \* \*

BAILEY, J. C. M., M.B.(Lond.), M.R.C.S., L.R.C.P., appointed House Surgeon to the West London Hospital.

\* \* \*

CARROLL, F. R., B.A.(Cantab.), M.R.C.S., L.R.C.P., appointed Surgeon to the ss. "Umvologi" (Natal Line).

\* \* \*

MART, W. T. D., B.A.(Cantab.), M.R.C.S., L.R.C.P., appointed Junior Assistant House Surgeon to the Royal Infirmary, Sheffield.

\* \* \*

POLLOCK, A. K. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the West London Hospital.

\* \* \*

THOMAS, C. J., M.B., B.Sc.(Lond.), D.P.H., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer to the School Board of London.

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WILLIAMSON, H., M.A., M.B., appointed Assistant Obstetric Physician to the Royal Hospital for Women and Children.

### New Addresses.

HAMER, W. H., 1A, Bramshill Gardens, Dartmouth Park Hill, N.W.

HEMING, J. J., 7, Eaton Road, Margate.

HOOLE, J., Parwick, Ashbourne, Derbyshire.

ROWE, W. T., 260, Woodborough Road, Nottingham.

TALBOT, E., 10, Bentinck Street, W.

### Birth.

SCORER.—On May 29th, at St. Cuthbert's, Christchurch Road, Bournemouth, to Frank and Violet Scorer, a son.